		FOR BHF USE					

LL1

2020
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT (COST REPORT)
FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2020)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH License ID Number: 0054262

Facility Name: Albany Care

Address: 901 Maple Avenue (Number) Evanston (City) 60202 (Zip Code)

County: Cook

Telephone Number: (847) 475-4000 **Fax #** (847) 475-8316

HFS ID Number:

Date of Initial License for Current Owners: 11/1/1991

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steven N. Lavenda **Telephone Number:** (847) 282-6300
Email Address:

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/20 to 12/31/20 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) (Date)
(Type or Print Name)
(Title)

Paid Preparer
(Signed) 05/21/2020 (Date)
** Subject to the attached Accountants' Consulting Report*
(Print Name and Title) Steven N. Lavenda, CPA — Partner
(Firm Name & Address) Marcum, LLP — 9 Parkway North, Suite 200 Deerfield, IL 60015
(Telephone) (847) 282-6300 Fax # (847) 282-6301

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	417	Intermediate (ICF)	417	152,622	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	417	TOTALS	417	152,622	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	121,194	2,095		123,289	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	121,194	2,095		123,289	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 80.78%

D. How many bed reserve days during this year were paid by the Department?
None (Do not include bed reserve days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 11/1/1991

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 11/1/1991 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/20 Fiscal Year: 12/31/20

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	587,748	86,742	74,551	749,041		749,041	(42,597)	706,444			1
2	Food Purchase		655,568		655,568	(24,888)	630,680	(7,058)	623,622			2
3	Housekeeping	468,030	75,423		543,453		543,453	(7,025)	536,428			3
4	Laundry		38,339	48,350	86,689		86,689	(999)	85,690			4
5	Heat and Other Utilities			317,895	317,895		317,895	(35,821)	282,074			5
6	Maintenance	111,294	64,187	242,245	417,726		417,726	(11,885)	405,841			6
7	Other (specify):*							12,650	12,650			7
8	**TOTAL General Services**	1,167,072	920,259	683,041	2,770,372	(24,888)	2,745,484	(92,734)	2,652,750			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	3,341,991	80,939	240,978	3,663,908		3,663,908	(22,205)	3,641,703			10
10a	Therapy											10a
11	Activities	191,422	13,272		204,694		204,694		204,694			11
12	Social Services	533,328		7,200	540,528		540,528		540,528			12
13	CNA Training											13
14	Program Transportation			1,057	1,057		1,057		1,057			14
15	Other (specify):*							30,288	30,288			15
16	**TOTAL Health Care and Programs**	4,066,741	94,211	249,235	4,410,187		4,410,187	8,083	4,418,270			16
	C. General Administration											
17	Administrative	134,232		1,256,146	1,390,378		1,390,378	(864,468)	525,910			17
18	Directors Fees											18
19	Professional Services			757,889	757,889	(1,245)	756,644	(551,062)	205,582			19
20	Dues, Fees, Subscriptions & Promotions			167,222	167,222		167,222	(84,912)	82,310			20
21	Clerical & General Office Expenses	436,591	108,188	347,299	892,078		892,078	232,009	1,124,087			21
22	Employee Benefits & Payroll Taxes			971,349	971,349	24,888	996,237	(11,182)	985,055			22
23	Inservice Training & Education											23
24	Travel and Seminar			6,447	6,447		6,447	(5,069)	1,378			24
25	Other Admin. Staff Transportation			18,810	18,810		18,810	(98)	18,712			25
26	Insurance-Prop.Liab.Malpractice			277,962	277,962		277,962	36,911	314,873			26
27	Other (specify):*							127,031	127,031			27
28	**TOTAL General Administration**	570,823	108,188	3,803,124	4,482,135	23,643	4,505,778	(1,120,841)	3,384,937			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	5,804,636	1,122,658	4,735,400	11,662,694	(1,245)	11,661,449	(1,205,492)	10,455,957			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Albany Care #0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR BHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			96,938	96,938		96,938	262,533	359,471			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			26,719	26,719		26,719	1,885,877	1,912,596			32
33	Real Estate Taxes			63,597	63,597	1,245	64,842	628,528	693,370			33
34	Rent-Facility & Grounds			3,282,000	3,282,000		3,282,000	(3,282,000)				34
35	Rent-Equipment & Vehicles			20,438	20,438		20,438	6,205	26,643			35
36	Other (specify):*							181,458	181,458			36
37	**TOTAL Ownership**			3,489,692	3,489,692	1,245	3,490,937	(317,399)	3,173,538			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee											42
43	Other (specify):*			60,000	60,000		60,000	(60,000)				43
44	**TOTAL Special Cost Centers**			60,000	60,000		60,000	(60,000)				44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	5,804,636	1,122,658	8,285,092	15,212,386	0	15,212,386	(1,582,892)	13,629,494			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 BHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(39,954)	05		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(106,035)	30		9
10	Interest and Other Investment Income	(120,343)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(111)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(54,100)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(4,016)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(8,000)	21		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(430,481)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (763,040)		$	30

BHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(819,851)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (819,851)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,582,891)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44						44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Albany Care

ID# 0054262

Report Period Beginning: 01/01/20

Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Legal Fees - Collections	$ (924)	21	1
2	Office Expense - Bank Fees	(11,655)	21	2
3	Office Exp - Credit Card Fees	(182)	21	3
4	Theft & Damage Loss	(2,277)	21	4
5	Bad Debts - Other	(255,118)	21	5
6	Capitalized R&M	(8,575)	06	6
7	PAC Dues	(33,848)	20	7
8	Non Allowable Legal	(22,842)	19	8
9	Prior Period Expense	(4,475)	21	9
10	Additional R&M	3,853	06	10
11	Line of Credit	(250)	20	11
12	Capitalized R&M	(8,575)	06	12
13	Building Co. - Accounting Fees	(11,900)	19	13
14	Building Co. - Licenses & Fees	(230)	20	14
15	Building Co. - Office Expense	(14)	21	15
16	Building Co. - Amortization	(4,858)	36	16
17	Builidng Co. - Replacement Tax	(8,612)	21	17
18	Non-Allowable Expense	(60,000)	43	18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(430,481)		49

Detail lines 29 and 35 of Page 5 starting in C12. **DO NOT DRAG AND DROP CELLS.**

The amounts in column F will transfer to the Adj. Summary column automatically.
The amounts in the Adj. Summary column are linked to pages Summary A and B.

STATE OF ILLINOIS **Page 5B**

Albany Care

IDF 0054262
Report Period Beginning: 01/01/20
Ending: 12/31/20

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
50		b		1
51				2
52				3
53				4
54				5
55				6
56				7
57				8
58				9
59				10
60				11
61				12
62				13
63				14
64				15
65				16
66				17
67				18
68				19
69				20
70				21
71				22
72				23
73				24
74				25
75				26
76				27
77				28
78				29
79				30
80				31
81				32
82				33
83				34
84				35
85				36
86				37
87				38
88				39
89				40
90				41
91				42
92				43
93				44
94				45
95				46
96				47
97				48
98	Total			49

Reference 1 Reference 2 Reference 3 Reference 4 Reference 5 Reference 6 Reference 7 Reference 9 Reference 10 Reference 10a Reference 11 Reference 12 Reference 13 Reference 14 Reference 15 Reference 17 Reference 18 Reference 19 Reference 20 Reference 21 Reference 22 Reference 23 Reference 24 Reference 25 Reference 26 Reference 27 Reference 30 Reference 31 Reference 32 Reference 33 Reference 34 Reference 35 Reference 36 Reference 38 Reference 39 Reference 40 Reference 41 Reference 42 Reference 43

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary				(41,786)		(811)						(42,597)	1
2	Food Purchase	(111)		(6,947)									(7,058)	2
3	Housekeeping						(7,025)						(7,025)	3
4	Laundry						(999)						(999)	4
5	Heat and Other Utilities	(39,954)			4,133								(35,821)	5
6	Maintenance	(13,297)	17,419	(20,453)	4,483		(36)						(11,885)	6
7	Other (specify):*			4,264	8,386								12,650	7
8	**TOTAL General Services**	(53,362)	17,419	(23,136)	(24,784)		(8,871)						(92,734)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records			(13,971)		(2,854)	(5,380)						(22,205)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	CNA Training													13
14	Program Transportation													14
15	Other (specify):*			30,288									30,288	15
16	**TOTAL Health Care and Programs**			16,317		(2,854)	(5,380)						8,083	16
	C. General Administration													
17	Administrative			(1,174,651)	310,183								(864,468)	17
18	Directors Fees													18
19	Professional Services	(34,742)	11,900	(560,181)	31,961								(551,062)	19
20	Fees, Subscriptions & Promotions	(92,444)	230	7,302									(84,912)	20
21	Clerical & General Office Expenses	(291,256)	8,626	514,379	260								232,009	21
22	Employee Benefits & Payroll Taxes			(10,800)		(382)							(11,182)	22
23	Inservice Training & Education													23
24	Travel and Seminar			(5,069)									(5,069)	24
25	Other Admin. Staff Transportation			(98)									(98)	25
26	Insurance-Prop.Liab.Malpractice		31,604	4,803	504								36,911	26
27	Other (specify):*			55,111	71,920								127,031	27
28	**TOTAL General Administration**	(418,443)	52,360	(1,169,204)	414,828	(382)							(1,120,841)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(471,804)	69,779	(1,176,023)	390,044	(3,236)	(14,252)						(1,205,492)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Albany Care # 0054262 **Report Period Beginning:** 01/01/20 **Ending:** 12/31/20

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(106,035)	358,023		10,545								262,533	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(120,343)	2,002,698	(4,127)	7,649								1,885,877	32
33	Real Estate Taxes		610,193		18,335								628,528	33
34	Rent-Facility & Grounds		(3,282,000)										(3,282,000)	34
35	Rent-Equipment & Vehicles			6,205									6,205	35
36	Other (specify):*	(4,858)	186,316										181,458	36
37	**TOTAL Ownership**	(231,236)	(124,770)	2,078	36,529								(317,399)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*	(60,000)											(60,000)	43
44	**TOTAL Special Cost Centers**	(60,000)											(60,000)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(763,040)	(54,992)	(1,173,945)	426,573	(3,236)	(14,252)						(1,582,892)	45

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Use Page 6-Supplemental as necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Page 6-Supplemental		See Page 6-Supplemental		See Page 6-Supplemental		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	Rent Income	$ 3,282,000	Albany Care LLC		$	$ (3,282,000)	1
2	V	32	Interest	246	Albany Care, LLC		2,002,944	2,002,698	2
3	V	36	Mortgage Insuarnce		Albany Care, LLC		181,458	181,458	3
4	V	20	Licenses & Fees		Albany Care, LLC		230	230	4
5	V	19	Accounting Fees		Albany Care, LLC		11,900	11,900	5
6	V	33	Real Estate Taxes	117,807	Albany Care, LLC		728,000	610,193	6
7	V	26	Property Insurance		Albany Care, LLC		31,604	31,604	7
8	V	36	Amortization		Albany Care, LLC		4,858	4,858	8
9	V	30	Depreciation		Albany Care, LLC		358,023	358,023	9
10	V	06	Repairs		Albany Care, LLC		17,419	17,419	10
11	V	21	Replacement Tax		Albany Care, LLC		8,612	8,612	11
12	V	21	Office Expense		Albany Care, LLC		14	14	12
13	V								13
14	Total			$ 3,400,053			$ 3,345,061	$ * (54,992)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	ELLIOTT AND RONNIE ROBINSON	2.386	AUBURN VILLAGE	AUBURN, IN	ALBANY CARE LLC	LINCOLNWOOD	BUILDING CO.	1
2	NOAH WOLFF REVOCABLE TRUST	4.357	BRYN MAWR CARE INC.	CHICAGO	GENERATIONS HEALTH NETW	LINCOLNWOOD	CONSULTING CO.	2
3	MARILYN WOLFF RECOVABLE TRUST	4.357	DECATUR MANOR HEALTHCARE,LLC	DECATUR	SIR PROPERTIES	LINCOLNWOOD	BUILDING CO.	3
4	LAURI WOLFF POLEN	1.439	GENERATIONS AT APPLEWOOD, LLC	MATTESON	OAKTON ARMS	DES PLAINES	ASSISTED LIVING	4
5	RANAN WOLFF	1.439	GENERATIONS AT ELMWOOD PARK, INC	ELMWOOD PARK	MAC Rx LLC	LIBERTYVILLE	PHARMACY	5
6	TZIONA ZEFFRN	1.439	GENERATIONS AT LINCOLN, LLC	LINCOLN	BIG TEN SUPPLY, LLC	HUNTLEY	SUPPLY CO.	6
7	ARI WOLFF	1.439	GENERATIONS AT NEIGHBORS, LLC	BYRON	TRANSITIONS INDIANA	EAST PEORIA	HOSPICE	7
8	CHERYL MAGENCE	1.439	GENERATIONS AT OAKTON PAVILION, LLC	DES PLAINES	GENERATIONS AT RIVERVIEW		ASSISTED & INDEPENDENT	8
9	ERIC ROTHNER	4.556	GENERATIONS AT PEORIA, LLC	PEORIA	SENIOR LIVING	EAST PEORIA	LIVING	9
10	MELISSA ROTHNER TRUST	1.199	GENERATIONS AT REGENCY, LLC	NILES				10
11	DANIEL ROTHNER TRUST	1.199	GENERATIONS AT RIVERVIEW, LLC	EAST PEORIA				11
12	WILLIAM ROTHNER TRUST	1.199	GENERATIONS AT ROCK ISLAND, LLC	ROCK ISLAND				12
13	RACHEL ROTHNER TRUST	1.199	GREENWOOD CARE, INC.	EVANSTON				13
14	ADAM VALES TRUST	1.199	PRAIRIE CREEK VILLAGE, LLC	DECATUR				14
15	KATHRYN VALES TRUST	1.199	VILLA CLARA POST ACUTE, LLC	DECATUR				15
16	DENNIS TOSSI	3.118	WILSON CARE, INC.	CHICAGO				16
17	JEFF ORAVEC	0.480						17
18	CHARLENE HILL- JEON	0.480						18
19	PATRICIA MCDIARMID	0.480						19
20	LISA FRIEDMAN	1.918						20
21	STEVE AND BARBARA GELLER	2.386						21
22	HARVEY SCOTT	0.480						22
23	LOUISE BERGTHOLD	0.719						23
24	THOMAS & STEPHANIE WINTER REV. TRUST	0.719						24
25	MICHAEL R GIANNINI TRUST DTD 3/13/00	7.314						25
26	CELESTE GIANNINI TRUST DTD 3/13/00	7.314						26
27	NORMAN MATTHEW QSST	7.953						27
28	SHELDON ROBINSON TRUST	4.374						28
29	FREDA ROBINSON TRUST DTD 10/21/83	4.374						29
30								30

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES

A. (Continued) **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions.**

	1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES			
	Name	Ownership %	Name	City	Name	City	Type of Business	
1	JULIANA BARRISH TRUST DATED 1/26/93	7.314						1
2	BRYAN BARRISH TRUST DTD 09/01/2004	7.314						2
3	EDWARD B. MATTHEW REVOCABLE TRUST	2.651						3
4	KENNETH MATTHEW	2.651						4
5	SAMUEL MATTHEW/ BRO TRUST	1.326						5
6	HARRISON MATTHEW/ BRO TRUST	1.326						6
7	SHELDON ROBINSON-LEVITT FAMILY TRUST	2.386						7
8	MELISSA ROTHNER	0.719						8
9	DANIEL ROTHNER	0.719						9
10	WILLIAM ROTHNER	0.719						10
11	RACHEL ROTHNER	0.719						11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	2	Dietary Other and Rebates	$	Generations HC Network, LLC		$ (6,947)	$ (6,947)	15
16	V	6	Repairs & Maintanence	42,876	Generations HC Network, LLC		33,823	(9,053)	16
17	V	7	Emp. Ben. - General Svc.		Generations HC Network, LLC		4,264	4,264	17
18	V	9	Medical Director Consults		Generations HC Network, LLC				18
19	V	10	Nursing	176,268	Generations HC Network, LLC		162,297	(13,971)	19
20	V	15	Emp. Ben. - Health Care		Generations HC Network, LLC		30,288	30,288	20
21	V	17	Administrative	1,226,146	Generations HC Network, LLC		51,495	(1,174,651)	21
22	V	19	Professional Fees	580,740	Generations HC Network, LLC		20,559	(560,181)	22
23	V	20	Fee, Subscriptions		Generations HC Network, LLC		7,302	7,302	23
24	V	21	Clerical & General	21,444	Generations HC Network, LLC		627,743	606,299	24
25	V	24	Education & Seminar		Generations HC Network, LLC		931	931	25
26	V	25	Other Admin. Staff Transportation		Generations HC Network, LLC		16,702	16,702	26
27	V	26	Insurance		Generations HC Network, LLC		4,803	4,803	27
28	V	27	Emp. Ben. - Gen. Admin.		Generations HC Network, LLC		55,111	55,111	28
29	V	32	Interest		Generations HC Network, LLC		(4,127)	(4,127)	29
30	V	35	Auto Rental		Generations HC Network, LLC		10,371	10,371	30
31	V	35	Equipment Rental		Generations HC Network, LLC		1,834	1,834	31
32	V								32
33	V	6	Repairs & Maintanence	11,400	Generations HC Network, LLC			(11,400)	33
34	V	21	Clerical and General	91,920	Generations HC Network, LLC			(91,920)	34
35	V	22	Employee Benefits	10,800	Generations HC Network, LLC			(10,800)	35
36	V	24	Education and Seminar	6,000	Generations HC Network, LLC			(6,000)	36
37	V	25	Other Admin. Staff Transportation	16,800	Generations HC Network, LLC			(16,800)	37
38	V	35	Equipment Rental	6,000	Generations HC Network, LLC			(6,000)	38
39	Total			$ 2,190,394			$ 1,016,449	$ * (1,173,945)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary Salaries	$ 57,168	Generations HC Network, LLC		$ 15,382	$ (41,786)	15
16	V	7	Emp. Ben. - Dietary		Generations HC Network, LLC		2,876	2,876	16
17	V	17	Admin./Legal Salaries		Generations HC Network, LLC		310,183	310,183	17
18	V	19	Fin. Consult./Regl. Dir.		Generations HC Network, LLC		30,953	30,953	18
19	V	27	Emp. Ben. - Administrative		Generations HC Network, LLC		71,920	71,920	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V	6	Maintenance Salaries	27,465	Generations HC Network, LLC		28,385	920	27
28	V	7	Employee Benefits		Generations HC Network, LLC		5,510	5,510	28
29	V								29
30	V	5	Utilities		Generations HC Network, LLC		4,133	4,133	30
31	V	6	Repairs & Maintenance		Generations HC Network, LLC		3,563	3,563	31
32	V	19	Professional Fees		Generations HC Network, LLC		1,008	1,008	32
33	V	21	Clerical & General		Generations HC Network, LLC		260	260	33
34	V	26	Insurance		Generations HC Network, LLC		504	504	34
35	V	30	Depreciation		Generations HC Network, LLC		10,545	10,545	35
36	V	32	Interest		Generations HC Network, LLC		7,649	7,649	36
37	V	33	Real Estate Taxes		Generations HC Network, LLC		18,335	18,335	37
38	V								38
39	Total			$ 84,633			$ 511,206	$ * 426,573	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	Nursing and Medical Records	$ 30,540	MAC Rx, LLC		$ 27,686	$ (2,854)	15
16	V	21	Clerical & General Office Expenses		MAC Rx, LLC				16
17	V	22	Employee Benefits	4,090	MAC Rx, LLC		3,708	(382)	17
18	V	39	Ancillary		MAC Rx, LLC				18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 34,630			$ 31,394	$ * (3,236)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$ 8,440	Big Ten Supply, LLC		$ 7,629	$ (811)	15
16	V	3	Housekeeping	73,093	Big Ten Supply, LLC		66,067	(7,025)	16
17	V	4	Laundry	10,390	Big Ten Supply, LLC		9,391	(999)	17
18	V	6	Repairs & Maintenance	378	Big Ten Supply, LLC		342	(36)	18
19	V	10	Nursing And Medical Records	55,977	Big Ten Supply, LLC		50,596	(5,380)	19
20	V	10A	Therapy		Big Ten Supply, LLC				20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 148,278			$ 134,026	$ * (14,252)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Bryan Barrish	Relative	Administrative	0	See Attached	5.19	12.96%	Alloc. Salary	$ 37,040	17-7	1
2	Burton Barrish	Relative	Administrative	0	See Attached	5.93	14.82%	Alloc. Salary	16,041	17-7	2
3	Sarah Barrish	Relative	Administrative	0	See Attached	7.41	14.82%	Alloc. Salary	19,045	17-7	3
4	Louise Bergthold	Owner	Administrative	0.72%	See Attached	8.89	14.82%	Alloc. Salary	37,040	17-7	4
5	Thomas Bergthold	Relative	Clerical	0	See Attached	5.93	14.82%	Alloc. Salary	8,970	21-7	5
6	Clark Collins	Relative	Administrative	0	See Attached	1.27	3.16%	Alloc. Salary	1,684	Various	6
7	Michael Giannini	Relative	Administrative	0	See Attached	5.93	13.17%	Alloc. Salary	56,748	17-3,17-7	7
8	Nenita Guzman	Relative	Dietary	0	See Attached	5.93	14.82%	Alloc. Salary	15,382	1-7	8
9	Jeff Oravec	Owner	Administrative	0.48%	See Attached	5.93	14.82%	Alloc. Salary	14,455	17-7	9
10	See Supplemental Schedule								67,810		10
11	Where applicable, the amounts reported on this page have been adjusted from the actual costs to reflect only the amounts										11
12	anticipated to be considered allowable by the IL. Dept. of HFS.										12
13								TOTAL	$ 274,213		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Generations HC Network, LLC
Street Address: 6840 N. Lincoln
City / State / Zip Code: Lincolnwood, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	2	Dietary Other and Rebates	Patient Days	832,144	19	$ (46,886)	$	123,289	$ (6,947)	1
2	6	Repairs & Maintanence	Patient Days	832,144	19	228,292	155,904	123,289	33,823	2
3	7	Emp. Ben. - General Svc.	Patient Days	832,144	19	28,781		123,289	4,264	3
4	9	Medical Director Consults	Patient Days	832,144	19			123,289		4
5	10	Nursing	Patient Days	832,144	19	1,095,433	1,094,370	123,289	162,297	5
6	15	Emp. Ben. - Health Care	Patient Days	832,144	19	204,429		123,289	30,288	6
7	17	Administrative	Patient Days	832,144	19	347,566	347,566	123,289	51,495	7
8	19	Professional Fees	Patient Days	832,144	19	138,762		123,289	20,559	8
9	20	Fee, Subscriptions	Patient Days	832,144	19	49,284		123,289	7,302	9
10	21	Clerical & General	Patient Days	832,144	19	4,236,976	3,850,828	123,289	627,743	10
11	24	Education & Seminar	Patient Days	832,144	19	6,287		123,289	931	11
12	25	Other Admin. Staff Transportatio	Patient Days	832,144	19	112,731		123,289	16,702	12
13	26	Insurance	Patient Days	832,144	19	32,419		123,289	4,803	13
14	27	Emp. Ben. - Gen. Admin.	Patient Days	832,144	19	371,977		123,289	55,111	14
15	32	Interest	Patient Days	832,144	19	(27,854)		123,289	(4,127)	15
16	35	Auto Rental	Patient Days	832,144	19	70,001		123,289	10,371	16
17	35	Equipment Rental	Patient Days	832,144	19	12,377		123,289	1,834	17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 6,860,575	$ 5,448,668		$ 1,016,449	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Generations HC Network, LLC
Street Address: 6840 N. Lincoln
City / State / Zip Code: Lincolnwood, IL. 60712
Phone Number: (847) 675 -7979
Fax Number: (847) 675 -0555

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary Salaries	Patient Days	832,144	19	$ 103,820	$ 103,820	123,289	$ 15,382	1
2	7	Emp. Ben. - Dietary	Patient Days	832,144	19	19,413		123,289	2,876	2
3	17	Admin./Legal Salaries	Patient Days	832,144	19	2,093,591	2,093,591	123,289	310,183	3
4	19	Fin. Consult./Regl. Dir.	Patient Days	832,144	19	208,920		123,289	30,953	4
5	27	Emp. Ben. - Administrative	Patient Days	832,144	19	485,424		123,289	71,920	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13	6	Maintenance Salaries	Maintenance Income	702,930	17	726,469	726,469	27,465	28,385	13
14	7	Employee Benefits	Maintenance Income	702,930	17	141,032		27,465	5,510	14
15										15
16	5	Utilities	Allocated Sq. Ft.	12,879	19	27,900		1,908	4,133	16
17	6	Repairs & Maintenance	Allocated Sq. Ft.	12,879	19	24,049		1,908	3,563	17
18	19	Professional Fees	Allocated Sq. Ft.	12,879	19	6,801		1,908	1,008	18
19	21	Clerical & General	Allocated Sq. Ft.	12,879	19	1,754		1,908	260	19
20	26	Insurance	Allocated Sq. Ft.	12,879	19	3,403		1,908	504	20
21	30	Depreciation	Allocated Sq. Ft.	12,879	19	71,181		1,908	10,545	21
22	32	Interest	Allocated Sq. Ft.	12,879	19	51,631		1,908	7,649	22
23	33	Real Estate Taxes	Allocated Sq. Ft.	12,879	19	123,763		1,908	18,335	23
24										24
25	TOTALS					$ 4,089,151	$ 2,923,880		$ 511,206	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MAC Rx, LLC
Street Address: 2307 S. Mount Prospect Road
City / State / Zip Code: Des Plaines, IL 60018
Phone Number: (224)220-2700
Fax Number: (224)220-2730

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing And Medical Records	Direct Allocation			$	$		$ 27,686	1
2	21	Clerical & General Office Expens	Direct Allocation							2
3	22	Employee Benefits	Direct Allocation						3,708	3
4	39	Ancillary	Direct Allocation							4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 31,394	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Big Ten Supply, LLC
Street Address: 15632 West Sprucewood Lane
City / State / Zip Code: Libertyville, IL 60048
Phone Number: (312)502-5882
Fax Number: (847)816-3425

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Direct Allocation			$	$		$ 7,629	1
2	3	Housekeeping	Direct Allocation						66,067	2
3	4	Laundry	Direct Allocation						9,391	3
4	6	Repairs & Maintenance	Direct Allocation						342	4
5	10	Nursing And Medical Records	Direct Allocation						50,596	5
6	10A	Therapy	Direct Allocation							6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 134,026	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Cambridge Capital		X	Mortgage			$	$ 32,622,954			$ 2,002,944	1
2							$	$			$	2
3							$	$			$	3
4							$	$			$	4
5							$	$			$	5
	Working Capital											
6	Wintrust Bank		X	Line of Credit				-			26,719	6
7								-			-	7
8												8
9	TOTAL Facility Related						$	$ 32,622,954			$ 2,029,663	9
	B. Non-Facility Related*											
10	Interest Income		X								(120,343)	10
11	Interest Income - Bldg Co.		X								(246)	11
12	Allocated from Generations He:										3,522	12
13												13
14	TOTAL Non-Facility Related						$	$			$ (117,067)	14
15	TOTALS (line 9+line14)						$	$ 32,622,954			$ 1,912,596	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 181,458 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2019 report.	**Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.**	$ 748,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 712,124	2
3. Under or (over) accrual (line 2 minus line 1).		$ (35,876)	3
4. Real Estate Tax accrual used for 2020 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 728,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 1,245	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 693,369	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2015	623,985	8
	2016	657,948	9
	2017	694,198	10
	2018	712,596	11
	2019	693,789	12

2020 Accrual = $693,789 x 1.05 = $728,000 (rounded)

Allocated from Generations Healthcare Network $18,335

	FOR BHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2019	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054262

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE (847) 282-6330 FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2019 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2019.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-19-121-019-000	Long Term Care Property	$ 693,789.25	$ 693,789.25
2.	See Attached	Regency Property, LLC	$ 796,746.36	$ 1,434.14
3.	See Attached	S.I.R. Properties, Inc.	$ 148,905.51	$ 17,276.48
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 1,639,441	$ 712,500

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach copies of the original 2019 tax bills which were listed in Section A to this statement. Be sure to use the 2019 tax bill which is normally paid during 2020.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates
RE: 2019 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2019 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2019.

Please complete the Real Estate Tax Statement below and include it in the 2020 cost report along with a copy of your 2019 real estate tax bill.

The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2019 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Albany Care COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0054262

CONTACT PERSON REGARDING THIS REPORT Steven Lavenda

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2015 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2015.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation and a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2015 tax bills which were listed in Section A to this statement. Be sure to use the 2015 tax bill which is normally paid during 2016.

PLEASE NOTE: ***Payment information from the Internet*** or otherwise is ***not considered acceptable tax bill documentation*** . Facilities located in Cook County are required to provide copies of their original **second installment** tax bill.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 211,753 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 7

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	24,573		$ 84,558	1
2					2
3	TOTALS	24,573		$ 84,558	3

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	417		1991	1972	$ 7,267,981	$ 358,023	35	$	$ (358,023)	$ 7,267,981	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	61,428		20	6	6	61,428	9
10	Various			1994	120,534		20	9	9	120,534	10
11	Various			1995	291,499		20	9	9	291,499	11
12	Various			1996	58,666		20	6	6	58,666	12
13	Various			1997	72,445		20	3	3	72,445	13
14	Various			1998	177,216		20	4	4	177,216	14
15	Various			1999	239,104		20	4	4	239,104	15
16	Various			2000	239,704		20	8,798	8,798	239,704	16
17	Various			2001	370,037		20	14,995	14,995	364,136	17
18	Various			2002	887,772		20	42,283	42,283	469,746	18
19	Various			2003	489,239		20	3,825	3,825	480,482	19
20	Various			2004	261,729		20	13,086	13,086	217,564	20
21	Various			2005	211,692		20	10,587	10,587	164,722	21
22	Various			2006	47,928		20	2,140	2,140	35,737	22
23	Various			2007	752,722		20	37,507	37,507	513,838	23
24	Various			2008	15,271		20	553	553	11,125	24
25	Various			2009	26,337		20	1,317	1,317	15,131	25
26	Various			2010	4,295		20	215	215	2,166	26
27	Various			2011	40,862		20	2,044	2,044	28,931	27
28	Various			2012	6,172		20	309	309	4,851	28
29	Various			2013	40,311		20	2,017	2,017	15,340	29
30	Various			2014	27,568		20	1,379	1,379	8,665	30
31	Various			2015	7,576		20	379	379	2,026	31
32	Various			2016	41,248		20	2,064	2,064	8,899	32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67	Related Building Company (Pages 12F & 12G)		2,680,191			134,015	134,015	1,462,924	67
68	Related Party Allocations (Pages 12H & 12I)		332,098	5,904		9,319	3,415	213,674	68
69	Financial Statement Depreciation			96,938			(96,938)		69
70	TOTAL (lines 4 thru 69)		$ 14,771,625	$ 460,865		$ 286,873	$ (173,992)	$ 12,548,534	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 14,771,625	$ 460,865		$ 286,873	$ (173,992)	$ 12,548,534	1
2	Penthouse Tuckpointing	2017	7,950		20	398	398	1,259	2
3	Elevator Work-Door Operator	2018	16,201		20	810	810	2,025	3
4	Sewer Upgrade In Basement	2018	6,500		20	325	325	785	4
5	Carpet Tile In Hallway	2018	53,305		20	2,665	2,665	5,997	5
6	Elevator Work-Governor	2018	7,506		20	375	375	844	6
7	Walk-In Cooler Upgrade	2018	6,000		20	300	300	625	7
8	Installed New Chexit Device	2019	3,519		20	176	176	352	8
9	Install 6 Battery Operated Exit Alarms	2019	2,940		20	147	147	294	9
10	Pests Clean Out & Installation Of 11 Drain Plugs	2019	3,105		20	155	155	310	10
11	Installed Boiler	2019	14,689		20	734	734	734	11
12	Repaired Leaks In Pipes	2020	7,995		20	400	400	400	12
13	Repaired Leaks In Pipes	2020	4,395		20	220	220	220	13
14	Repaired Cafeteria Emergency Exit Door	2020	4,998		20	250	250	250	14
15	Plumbing Work In Kitchen	2020	5,285		20	264	264	264	15
16	Install Doors - 2Nd & 5Th Flr Stairwells	2020	3,290		20	165	165	165	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,919,303	$ 460,865		$ 294,257	$ (166,608)	$ 12,563,057	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 14,919,303	$ 460,865		$ 294,257	$ (166,608)	$ 12,563,057	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,919,303	$ 460,865		$ 294,257	$ (166,608)	$ 12,563,057	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 14,919,303	$ 460,865		$ 294,257	$ (166,608)	$ 12,563,057	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,919,303	$ 460,865		$ 294,257	$ (166,608)	$ 12,563,057	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 14,919,303	$ 460,865		$ 294,257	$ (166,608)	$ 12,563,057	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 14,919,303	$ 460,865		$ 294,257	$ (166,608)	$ 12,563,057	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Building Company		$	$		$	$	$	1
2									2
3									3
4									4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Various	2008	741,248		20	37,062	37,062	481,812	9
10	Various	2009	431,004		20	21,550	21,550	284,521	10
11	Various	2010	690,733		20	34,537	34,537	379,912	11
12	Various	2011	339,451		20	16,973	16,973	175,730	12
13	Various	2012	86,951		20	4,348	4,348	39,129	13
14	Various	2013	117,956		20	5,898	5,898	47,183	14
15	Various	2014	20,530		20	1,027	1,027	7,187	15
16	Various	2015	37,250		20	1,863	1,863	11,176	16
17	Replace tub drains in rooms 302/303	2016	3,600		20	180	180	900	17
18	Boiler work	2016	8,178		20	409	409	2,045	18
19	Digangi plumbing & replaced storage tank	2016	8,400		20	420	420	2,100	19
20	Urban elevator service - Elevator GAL door opener	2016	15,451		20	773	773	3,863	20
21	Wireless WIFI upgrade	2017	5,275		20	264	264	1,055	21
22	Boiler work - Tubes and manway cover	2017	5,631		20	282	282	1,127	22
23	Boiler work - Tubes replacement	2017	3,378		20	169	169	676	23
24	Water softener system	2017	3,116		20	156	156	623	24
25	Stairwell exit door	2017	2,865		20	143	143	573	25
26	Eastman boiler	2017	21,674		20	1,084	1,084	4,335	26
27	Elevator door operator	2017	15,979		20	799	799	3,196	27
28	Boiler work - Component replacement	2017	8,828		20	441	441	1,765	28
29	HVAC - Main exhaust	2017	4,618		20	231	231	924	29
30	Steam leak repair - Replacement piping	2017	17,000		20	850	850	3,400	30
31	Replaced exterior lighting	2017	2,554		20	128	128	511	31
32	Boiler work	2017	4,613		20	231	231	923	32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,596,283	$		$ 129,818	$ 129,818	$ 1,454,666	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 2,596,283	$		$ 129,818	$ 129,818	$ 1,454,666	1
2	Roof Work	2018	2,700		20	135	135	540	2
3	Plumbing works/Repair of shower valves & sink line	2018	3,725		20	186	186	745	3
4	Replace drain line from sink through kitchen floor / Replace hot & col	2018	2,850		20	143	143	571	4
5	Remove, rebuild, and re-install pump motor/Installed new thermal	2018	3,186		20	159	159	637	5
6	Replace storage drain	2018	2,750		20	138	138	551	6
7	Boiler return line replacement	2019	8,300		20	415	415	830	7
8	New elevator car sill & paint	2019	13,897		20	695	695	1,390	8
9	A/C compressor & other work	2019	3,600		20	180	180	360	9
10	Hot water piping	2019	2,750		20	138	138	276	10
11	Kitchen gas leak repair	2019	6,990		20	350	350	700	11
12	Kitchen Valve/Plumbing Replacements	2020	4,995		20	250	250	250	12
13	Repaired Elevator	2020	23,349		20	1,167	1,167	1,167	13
14	Installed Garage Light Fixtures	2020	4,816		20	241	241	241	14
15			-						15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,680,191	$		$ 134,015	$ 134,015	$ 1,462,924	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Related Party		$	$		$	$	$	1
2	Buildings:								2
3	Allocated from Generations Healthcare Network, LLC	2009	74,074	1,977	39	1,899	(78)	20,972	3
4	Allocated from S.I.R. Properties/GHN	1993	67,061	2,129	35	1,916	(213)	50,774	4
5									5
6									6
7									7
8	Leasehold Improvements:								8
9	Allocated from Generations Healthcare Network, LLC	1993	17,002	473	20		(473)	17,002	9
10	Allocated from Generations Healthcare Network, LLC	1994	53		20			53	10
11	Allocated from Generations Healthcare Network, LLC	1995	389		20			389	11
12	Allocated from Generations Healthcare Network, LLC	1997	26,125	585	20		(585)	26,125	12
13	Allocated from Generations Healthcare Network, LLC	1999	2,054		20	78	78	2,054	13
14	Allocated from Generations Healthcare Network, LLC	1999	23,330		20			23,330	14
15	Allocated from Generations Healthcare Network, LLC	2000	2,425		20	55	55	2,425	15
16	Allocated from Generations Healthcare Network, LLC	2007	7,793		20	390	390	5,141	16
17	Allocated from Generations Healthcare Network, LLC	2008	21,476		20	794	794	15,708	17
18	Allocated from Generations Healthcare Network, LLC	2009	53,364		20	2,668	2,668	30,003	18
19	Allocated from Generations Healthcare Network, LLC	2011	1,320	132	20	132		1,243	19
20	Allocated from Generations Healthcare Network, LLC	2012	4,225	211	20	211		1,567	20
21	Allocated from Generations Healthcare Network, LLC	2014	593	59	20	30	(29)	195	21
22	Allocated from Generations Healthcare Network, LLC	2016	770	39	20	39		170	22
23	Allocated from Generations Healthcare Network, LLC	2019	3,843	189	20	189		240	23
24	Allocated from Generations Healthcare Network, LLC	2020	3,131	65	20	65		65	24
25	Allocated from S.I.R. Properties/GHN	2012	4,108		20	205	205	1,439	25
26	Allocated from S.I.R. Properties/GHN	2010	4,047		20	202	202	1,889	26
27	Allocated from S.I.R. Properties/GHN	2009	4,027		20	201	201	2,174	27
28	Allocated from S.I.R. Properties/GHN	2007	397	23	20	20	(3)	258	28
29	Allocated from S.I.R. Properties/GHN	2002	266		20	13	13	233	29
30	Allocated from S.I.R. Properties/GHN	1999	8,498		20	212	212	8,498	30
31	Allocated from S.I.R. Properties/GHN	1994	639	16	20		(16)	639	31
32	Allocated from S.I.R. Properties/GHN	1993	1,088	6	20		(6)	1,088	32
33									33
34	TOTAL (lines 1 thru 33)		$ 332,098	$ 5,904		$ 9,319	$ 3,415	$ 213,674	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

B. Building and Improvement Costs-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 332,098	$ 5,904		$ 9,319	$ 3,415	$ 213,674	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 332,098	$ 5,904		$ 9,319	$ 3,415	$ 213,674	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XI. OWNERSHIP COSTS (continued)

C. Equipment Costs-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 769,353	$ 3,142	$ 60,584	$ 57,442	10	$ 738,100	71
72	Current Year Purchases	20,118	41	1,991	1,950	10	1,991	72
73	Fully Depreciated Assets	1,414,152				10	1,414,152	73
74								74
75	TOTALS	$ 2,203,623	$ 3,183	$ 62,575	$ 59,392		$ 2,154,243	75

D. Vehicle Costs. (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79		See Attached		17,469	1,457	2,638	1,181		9,360	79
80	TOTALS			$ 17,469	$ 1,457	$ 2,638	$ 1,181		$ 9,360	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 17,224,953	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 465,505	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 359,470	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (106,035)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 14,726,660	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	Wiring - Internet/Phones	$ 2,254	92
93			93
94			94
95		$ 2,254	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2021	$
13.	/2022	$
14.	/2023	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 16,272 Description: See Attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Allocated from Generatio		$	$ 10,371	17
18					18
19					19
20					20
21	TOTAL		$	$ 10,371	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Other (specify):									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/20 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 870,539	$ 1,422,856	1
2	Cash-Patient Deposits	165,090	165,090	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	(295,422)	(295,422)	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	40,413	103,044	6
7	Other Prepaid Expenses	304,157	304,157	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):		1,405,668	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,084,777	$ 3,105,393	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		84,558	13
14	Buildings, at Historical Cost		7,267,981	14
15	Leasehold Improvements, at Historical Cost	3,534,448	6,161,643	15
16	Equipment, at Historical Cost	2,368,529	3,020,163	16
17	Accumulated Depreciation (book methods)	(4,363,139)	(13,092,239)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	5,522,327	5,638,107	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 7,062,165	$ 9,080,213	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 8,146,942	$ 12,185,606	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 528,063	$ 528,064	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	165,177	165,177	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	512,761	512,761	30
31	Accrued Taxes Payable (excluding real estate taxes)	282,811	282,811	31
32	Accrued Real Estate Taxes(Sch.IX-B)		728,000	32
33	Accrued Interest Payable		73,402	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		3,096,853	3,166,926	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 4,585,665	$ 5,457,141	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable		32,622,954	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43			2,756,290	43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 35,379,244	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,585,665	$ 40,836,385	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 3,561,277	$ (28,650,779)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 8,146,942	$ 12,185,606	48

***(See instructions.)**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 3,311,723	1
2	Restatements (describe):		2
3	Rounding	2	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 3,311,725	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	249,552	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 249,552	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 3,561,277	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	I. Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 15,030,108	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 15,030,108	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	120,343	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 120,343	26
	E. Other Revenue (specify):**		
27	**Settlement Income (Insurance, Legal, Etc.)**		27
28		311,487	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 311,487	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,461,938	30

	II. Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,770,372	31
32	Health Care	4,410,187	32
33	General Administration	4,482,135	33
	B. Capital Expense		
34	Ownership	3,489,692	34
	C. Ancillary Expense		
35	Special Cost Centers	60,000	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,212,386	40
41	**Income before Income Taxes (line 30 minus line 40)****	249,552	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 249,552	43

	III. Net Inpatient Revenue detailed by Payer Source		
44	Medicaid - Net Inpatient Revenue	$ 2,080,994	44
45	Private Pay - Net Inpatient Revenue	276,470	45
46	Medicare - Net Inpatient Revenue		46
47	Other-(specify) Managed Care	12,672,644	47
48	Other-(specify)		48
49	TOTAL Inpatient Care Revenue (This total must agree to Line 3)	$ 15,030,108	49

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,994	2,091	$ 142,753	$ 68.27	1
2	Assistant Director of Nursing	1,977	2,106	73,372	34.84	2
3	Registered Nurses	3,338	3,899	124,480	31.93	3
4	Licensed Practical Nurses	32,641	35,038	1,027,367	29.32	4
5	CNAs & Orderlies	91,782	98,703	1,797,311	18.21	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	9,845	11,364	191,422	16.84	10
11	Social Service Workers	28,587	30,461	533,072	17.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	32,032	35,094	587,748	16.75	15
16	Dishwashers					16
17	Maintenance Workers	5,628	6,324	111,294	17.60	17
18	Housekeepers	27,171	29,264	468,030	15.99	18
19	Laundry					19
20	Administrator	1,922	2,107	126,704	60.13	20
21	Assistant Administrator	257	257	7,528	29.29	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,689	27,545	436,591	15.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	5,986	6,554	174,124	26.57	31
32	Other Health Care(specify)					32
33	Other(specify) See Attached	201	201	2,840	14.15	33
34	TOTAL (lines 1 - 33)	269,050	291,008	$ 5,804,636 *	$ 19.95	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	$ 74,551	01-03	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	176,268	10-03	38
39	Pharmacist Consultant	Monthly	26,880	10-03	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47	Psychiatric MD	Monthly	7,200	12-03	47
48					48
49	TOTAL (lines 35 - 48)		$ 284,899		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	863	$ 37,095	10-03	50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	23	735	10-03	52
53	TOTAL (lines 50 - 52)	886	$ 37,830		53

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Konstantinos Stavropoulos	Administrator		$ 38,661
Deborah Vege	Administrator		88,143
Richard Ogunniyi	Asst. Administrator		7,428
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 134,232

B. Administrative - Other

Description	Amount
SIR/Generations HN - Dir. of Administrative Services	$ 166,740
SIR/Generations HN - Consulting Fees	1,059,406
SIR/Generations HN - Director Fee - Michael Giannini	30,000
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 1,256,146

C. Professional Services

Vendor/Payee	Type	Amount
Marcum LLP	Accounting Fees	$ 17,700
Pinnacle	Customer Satisfaction	995
Paylocity	Payroll Processing	15,686
PayChex	Payroll Processing	297
The Joint Commission	Accreditation	10,850
Amari & Locallo	Real Estate Appeal	450
SIR/Generations HN	Dir. of Financial Services	111,960
SIR/Generations HN	Dir. of Business Development	128,628
SIR/Generations HN	Dir. of Regulatory Services	57,168
SIR/Generations HN	Dir. of Information Technology	28,584
See Attached	Legal	26,397
See Supplemental Schedule		359,174
TOTAL (agree to Schedule V, line 19, column 3) (For legal fee disclosure, see page 39 of instructions)		$ 757,889

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 44,703
Unemployment Compensation Insurance	21,488
FICA Taxes	444,054
Employee Health Insurance	384,057
Employee Meals	24,888
Illinois Municipal Retirement Fund (IMRF)*	
Employee Benefits - Other	11,096
Union Pension Plan	51,871
401K Matching Contr.	2,898
TOTAL (agree to Schedule V, line 22, col.8)	$ 985,054

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 4,206
Advertising: Employee Recruitment	10,603
Health Care Worker Background Check	
(Indicate # of checks performed 205)	2,050
Patient Background Checks 319	3,190
Dues & Subscriptions	20,434
Licenses & Fees	34,525
See Supplemental Schedule	7,302
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 82,310

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	6,447
See Supplemental Schedule	(5,069)
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,378

**See instructions.

Facility Name & ID Number Albany Care # 0054262 Report Period Beginning: 01/01/20 Ending: 12/31/20

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Alliance for Living - $33,848**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **1,643** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ ____
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **24,888** Has any meal income been offset against related costs? **No** Indicate the amount. $ ____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **100% Ln 14**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) Has a schedule for the legal fees reported on the cost report been provided by the facility? See page 39 of the instructions for details. **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.